

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-033040

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE  
ON THIS STUD

AMENDED

Registration District No. 245 Primary Registration District No. 3047 Registrar's No. III

STATE FILE NUMBER

FILED AUG 26 1963

1. PLACE OF DEATH a. COUNTY <u>Newton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Newton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Neosho</u>		c. CITY OR TOWN <u>Neosho</u>	
Length of stay in 1b <u>1 Hr</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>Sale Memorial Ho spital</u>		d. STREET ADDRESS (If outside, give location) <u>Route # 3</u>	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Delmar Wayne Hayes</u>		4. DATE OF DEATH Month <u>August</u> Day <u>15</u> Year <u>1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-6-1920</u>
9. AGE (last birthday) <u>43</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
11. IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rocketdyne</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Machine Shop</u>	
11. BIRTHPLACE (City and state or country) <u>Licking, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Grover Hayes</u>		13b. MOTHER'S MAIDEN NAME <u>Callie Jones</u>	
14. NAME OF HUSBAND OR WIFE <u>Margreat</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>Yes U War # 2</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Margreat Hayes</u>		Address <u>Neosho, Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>  </u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>  </u>		PART III. If deceased was female was there a pregnancy in last 90 days <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>  </u>	
20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. CITY, TOWN, OR LOCATION <u>Neosho</u>		COUNTY <u>  </u> STATE <u>  </u>	
21. I attended the deceased from <u>7-15-63</u> to <u>7-15-63</u> and last saw him alive on <u>7-15-63</u> . Death occurred at <u>9:50 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>		22b. ADDRESS <u>113 W. Hickory</u> <u>Neosho, Missouri</u>	
22c. DATE SIGNED <u>8-19-63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-19-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Swars Prairie</u>	
23d. LOCATION (City, town, or county) <u>10 mi West Neosho, Mo</u>		(State) <u>  </u>	
24. FUNERAL DIRECTOR <u>Clark Funeral Home</u>		25. DATE RECD. BY LOCAL REG. <u>8-19-63</u>	
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 29 1963  
AUG 30 1963

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed H. Wayne Swain

Licensed Embalmer No. 5191

P. O. Address 632 Park St.

Meriden, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.